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NAME OF PROVIOER OR SUPPLIER	STREET AODRESS. CITY. STATE. ZIP COOE
ALBEMARLE HEALTH AND REHABILITATION CENTER	1540 FOUNDERS PLACE CHARLOTTESVILLE, VA 22902

(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH OEFICIENCY MUST BE PRECEOEO BY FULL REGULATORY OR LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCEO TO THE APPROPRIATE OEFICIENCY)	(X5) COMPLETION DATE
(F 000)	INITIAL COMMENTS An unannounced Medicare/Medicaid second revisit to the abbreviated standard survey conducted on 6/7/16 through 6/9/16 was conducted on 8/31/16 through 9/1/16. The first revisit survey was conducted 7/26/16 through 7/27/16. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. No complaints were investigated during this survey. The census in this 120 certified bed facility was eighty-one at the time of the survey. The survey sample consisted of ten current resident reviews (Residents 201 through 210).	(F 000)	The statements included are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance of state and federal regulations as outlined. To remain in compliance with all federal and state regulations the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated.	
(F 281) SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review, the facility staff failed to follow professional standards of nursing during medication administration for one of 10 residents, Resident #202. a.) Resident #202 was given another resident's medication IV (intravenous) Zosyn (an antibiotic) on 08/20/2016. b.) Facility staff administered 1500 mg (milligrams) of Vancomycin IV from 08/24/2016 until 08/31/2016, a total of 8 doses, eventhough the POS (physician order sheet) and the MAR	(F 281)	**F281** **How the corrective action will be accomplished for the resident(s) affected.** Order was confirmed and entered into Point Click Care to increase Vancomycin to 1.5 Gm on Patient #202. Pharmacy had filled and provided 1.5 Gm since 8/24/2016.	**09/08/16**

LABORATORY OIRECTOR'S OR PROVIOER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Jennifer J Davis	Administrator	9/8/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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ALBEMARLE HEALTH AND REHABILITATION CENTER	1540 FOUNDERS PLACE CHARLOTTESVILLE, VA 22902

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{F 281}	Continued From page 1	{F 281}	**How corrective action will be accomplished for those residents with the potential to be affected by the same practice.**	

(medication administration record) read that Vancomycin 1 gram (1,000 milligrams) was to be administered.

Findings were:

Resident #202 was admitted to the facility on 08/09/2016. His diagnoses included but were not limited to: Cellulitis, peripheral vascular disease, COPD (chronic obstructive pulmonary disease), Type II (two) Diabetes mellitus, and recent fem-pop (femoral-popliteal) bypass survey.

The most recent MDS (minimum data set) was an initial/admission assessment with an ARD (assessment reference date) of 08/15/2016. Resident #202 was assessed as having a cognitive summary score of "10", indicating moderate impairment with his cognitive status.

a.) Initial tour of the facility was conducted on 08/31/2016 at approximately 11:15 a.m. Resident #202 was not in his room. Observed at his bedside was an IV pump with two empty IV bags and tubing hang from the IV pole. Both bags were labeled with Resident #202's name. One empty bag was labeled as "Zosyn 3.375 gm" and the other as "Vancomycin 1500 mg".

The electronic record was reviewed. Observed in the nurse's note section were the following entries:

"08/20/2016 19:18 [7:18 p.m.] Notified RP [responsible party] daughter [name] of medication error this morning. Zosyn 3.375 g [Grams] ordered for resident, resident received Zosyn 2.25 g. On call MD, [name], notified. No new orders at this time."

Current patients will be reviewed to identify potential services that failed to meet and/or follow professional standards of nursing practice to include administration of correct IV antibiotics and order entry. No other patients failed to meet and/or follow professional standards of nursing practice including administration of correct IV antibiotics and order entry.

Measures in place to ensure practices will not occur.

Charge nurses will be in-serviced on meeting professional standards of nursing practice to include the 7 rights of medication administration.

How the facility plans to monitor and ensure correction is achieved and sustained.

UM/designee will review new orders and verify IV antibiotic orders with correct supply 5 times a week for 4 weeks to identify any departure from standards of nursing practice including the 7

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(F 281)	Continued From page 2 "08/21/2016 05:00 [5:00 a.m.] Two patient's (sic) receiving the same drug but different dose. The bags were switched so patient got lower dose than he should have gotten." A copy of an incident report regarding the above medication error was requested and received. The report read that the nurse who had administered the wrong medication to the wrong resident was inserviced on 08/21/2016 regarding the five rights of medication administration. Also presented was a handwritten statement from the DON (director of nursing) dated 08/22/2016 regarding the error. The statement read: "Investigation of med error of 08/20/16 discovered Resident received lower dose of IV Zosyn that what he was ordered. Another resident on the same unit also had IV Zosyn stored in the same fridge. The nurse transposed the bags. Nurse [name] received educallon on the five rights, MD's, RP's were all notifled. No adverse reactions were noted on resident. No new orders received." b.) The physlcian orders in the clinical record were reviewed. Observed on the POS (physician order sheet) were the following orders: "Vancomycin HCL in Dextrose Solution 1 gm/200 ml [1 gram per 200 milliliters]. Use 200 ml intravenously every 24 hours related to CELLULITIS..." The elecIronic MAR (medication administration record) was reviewed. The above order was observed on the MAR. There were nurse's initlals present indicating the medlcation was glven every day as ordered.	(F 281)	rights of medication administration pass. Any deficient practice will result in re-education disciplinary action as indicated. Findings will be reviewed at the Q&A meeting for tracking and trending.	

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The paper record was reviewed. Observed in the physician order section was notification from the pharmacy handling Resident #202's IV Vancomycin. The following information was observed on the notification:

"Attention: [Name of facility]
Date: 8/19/2016
Patient: [Resident #202's name]
VANCOMYCIN LEVELS FROM: Vancomycin 1 gm IV Q 24 [every 24 hours]
Date: 8/18/16
Trough: 6.8 (10-20 mcg/ml) [desired levels of medication in the bloodstream] RECOMMEND (verify with MD/NP [medical doctor/nurse practitioner] & transcribe new order): Change dose: [arrow pointing upward symbolizing increase] Vancomycin 1500 mg [milligrams] IV 24 Next Levels: with 4th dose"

The notification was signed by the pharmacist. The recommendation was not signed by the physician or the nurse practitioner.

The refrigerator on Unit 2 was inspected as part of the survey process. Observed in the refrigerator were refrigerator were two prepared bags of Vancomycin 1500 mg labeled with Resident #202's name.

The DON and the corporate nurse consultant were interviewed regarding Resident #202's Vancomycin dosage. The pharmacy recommendation was shown to them and a copy requested.

A meeting was held with the facility staff on 08/31/2016 at approximately 4:45 p.m. The above information was discussed. Presented to

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this surveyor was the above described pharmacy notification that was signed by the nurse practitioner on 08/24/2016. The DON was asked where the signed notification came from. She stated, "It was at the pharmacy."

The DON and the corporate nurse consultant were asked what dosage of Vancomycin was ordered at the facility. The DON stated, "Our orders are for 1 gram...The signed order was at the pharmacy, not here...our orders here were not updated to the 1500 mg."

On 09/01/2016 at approximately 8:40 a.m., the DON came to the conference room to present requested documentation to the survey team. She stated, "We did not have an order for 1500 mg of Vancomycin. Our order was for 1 gram. The nurses hung 1500 mg, that was the wrong dose."

On 09/01/2016 the physician orders and the MAR were again reviewed. The Vancomycin order was not changed to 1500 mg. The night shift dosage of Vancomycin was signed off as 1 gm being administered.

During a meeting with the administrator, OS #4, and the corporate nurse consultant at 9:45 a.m., this surveyor asked why the orders were not yet changed for the Vancomycin and why did the night shift nurse still sign off as giving 1 gm when they were actually administering 1500 mg. They stated they would find out.

OS #4 and the administrator came back to speak with this surveyor at 10:45 a.m. regarding the dosage of Vancomycin and why the order was not

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changed to reflect the 1500 mg dosage. OS #4 stated, "The nurses last night were really just signing off that they gave the Vancomycin...we communicated with them in shift cross-over report that the dosage was now 1500 mg and that is what they were to hang...the order should have been changed, it is changed now." OS #4 was told that there were no notes in the nurse's note section indicating that the nurse knew she was signing off on a different dose of medication than what was actually given. OS #4 made no comment.

The NP who signed the Vancomycin increase recommendation was interviewed on 09/01/2016 at approximately 10:55 a.m. She was asked what the process was for the Vancomycin order. She stated, "The pharmacy makes recommendations based on the Vancomycin levels. They recommended on August 18 to increase the Vancomycin to 1500 mg...that recommendation went in my folder. I signed it on 08/24/2016 and gave it to the nurse." The NP was asked if she faxed the recommendation to the pharmacy. She stated, "No, I signed it and gave it to the nurse...I don't know what they did with it from there."

OS #4 and the administrator were in the room during the interview with the NP. They were asked who was responsible for changing the order in the POS and on the MAR. OS #4 stated the nurse who faxed the order to the pharmacy. OS #4 was asked who that nurse was. He stated, "We don't know...that's not part of our process." OS #4 also stated, "We just got confirmation from the pharmacy...they started sending the 1500 mg of Vancomycin on 08/24/2016." OS #4 and the administrator were asked, "So [name of Resident #202] has been

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getting an increased dose of Vancomycin since August 24th without a physician order at the facility and the nurses have been hanging the incorrect dose since then (08/24/2016)" OS #4 stated, "Yes."

Due to the fact that the Vancomycin was administered on the night shift, the nurses who administered the medication were not available for interview.

A copy of the facility's professional standards for the administration of medications and the facility policy for medication administration was requested. The nurse consultant presented a "Medication Administration Review For Long Term Care Centers" checklist. She stated, "We do not have a specific policy regarding medication administration...this is the checklist that is used when the nurses are observed giving medications." The Checklist included but was not limited to: "Each medication checked for: Right resident, Right drug, Right dose. Right dosage form, Right route, Right Time and frequency, Medications checked three times." The corporate nurse consultant was asked if there were any publications the facility used regarding nursing practice. She stated, "No, we go by company guidelines." She stated, "We have something from the pharmacy that we use." A copy of whatever was used as the professional standard for medication administration was requested.

An education tool used by the facility's pharmacy services titled "Medication Pass Fundamentals Part 2: The 7 Rights, 3 Way Check, Basics of Preparing and Administering: Oral, Ophthalmic, Otic and Nasal Medication, Common Errors" was presented. The nurse consultant was asked if

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{F 281}	Continued From page 7 that was the professional standard used by the facility. She stated, "Yes." Information in the education tool included but were not limited to: "...Look at the MAR-never go by memory or by just looking at the medications/medication cards... How to Begin-Preparing medication doses: 3 Way Check: 1. Compare each medication to the order on the MAR as it is removed from the resident's medication drawer-check the resident's name, drug name, dosage form, strength of concentration, dosage administration route, frequency, duration and time it is to be given -If there ever is a difference between the MAR and the medication STOP -take action: Review the order in the chart, check with your supervisor, call the pharmacy if needed - Do not give the medication until you know the order is correct and the order has been corrected on the MAR 2. Compare the drug to the MAR after it is prepared/poured 3. Compare as you return the medication to storage/immediately before administration to the resident". (1) No further information was obtained prior to the exit conference on 09/01/2016. (1) Medication Pass Fundamentals Part 2: The 7 Rights, 3 Way Check, Basics of Preparing and Administering: Orat, Ophthalmic, Otic and Nasal Medications, Common Errors. Carrie Allen Pharm D. CGP, BCPS, CCHP. Omnicare Pharmacy Services. 4/2014.	{F 281}		
{F 309} SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must	{F 309}		

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provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced by:
Based on staff interview, facility document review and clinical record review the facility staff failed to follow physician orders for one of 10 residents, Resident #202.

a.) Resident #202 received the wrong dosage of tV (intravenous) Zosyn on one occasion (08/20/2016) due to a medication error.

b.) Facility staff failed to follow physician's orders to measure Resident #202's arm circumference three inches above his PICC (peripherally inserted central catheter) line catheter insertion site every Tuesday, for a total of four missed opportunities.

Findings were:

Resident #202 was admitted to the facility on 08/09/2016. His diagnoses included but were not limited to: Cellulitis, peripheral vascular disease, COPD (chronic obstructive pulmonary disease), Type II (two) Diabetes mellitus, and recent fem-pop (femoral-popliteal) bypass survey.

The most recent MDS (minimum data set) was an initial/admission assessment with an ARD (assessment reference date) of 08/15/2016.

How the corrective action will be accomplished for the resident(s) affected.

Order was confirmed and entered into Point Click Care to increase Vancomycin to 1.5 Gm on Patient #202. Pharmacy had filled and provided 1.5 Gm since 8/24/2016. Order was obtained on 91/2016 to discontinue measurements above PICC line for Patient #202.

How corrective action will be accomplished for those residents with the potential to be affected by the same practice.

Current patients will be reviewed to identify patients receiving IV antibiotics to ensure correct dose and order entry.
No other patients had incorrect IV antibiotic dosages or orders for measurements above the PICC line.

Measures in place to ensure practices will not occur.

Charge nurses will be in-serviced on the 7 rights of medication

administration pass and following physician orders.

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(F 309)	Continued From page 9 Resident #202 was assessed as having a cognitive summary score of "10", indicating moderate impairment with his cognitive status. a.) The electronic record was reviewed. Observed in the nurse's note section were the following entries: "08/20/2016 19:18 [7:18 p.m.] Notified RP [responsible party] daughter [name] of medication error this morning. Zosyn 3.375 g [Grams] ordered for resident, resident received Zosyn 2.25 g. On call MD, [name], notified. No new orders at this time." "08/21/2016 05:00 [5:00 a.m.] Two patient's [sic] receiving the same drug but different dose. The bags were switched so patient got lower dose than he should have gotten." A copy of an incident regarding the above medication error was requested and received. The nurse who had administered the wrong medication to the wrong resident was inserviced on 08/21/2016 regarding the five rights of medication administration. Also presented was a handwritten statement from the DON (director of nursing) dated 08/22/2016 regarding the error. The statement read: "Investigation of med error of 08/20/16 discovered Resident received lower dose of IV Zosyn that what he was ordered. Another resident on the same unit also had IV Zosyn stored in the same fridge. The nurse transposed the bags. Nurse [name] received education on the five rights, MD's, RP's were all notified. No adverse reactions were noted on resident. No new orders received." The physician orders in the clinical record were	(F 309)	**How the facility plans to monitor and ensure correction is achieved and sustained.** UM/designee will review new orders and verify IV antibiotic and PICC orders with correct supply 5 times a week for 4 weeks. Any deficient practice will result in re-education or disciplinary action as indicated. Findings will be reviewed at the Q&A meeting for tracking and trending.	

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reviewed. Observed on the POS (physician order sheet) were the following orders: "Zosyn Solution Reconstituted 3.375 GM (grams) Use 1 dose IV every 6 hours related to CELLULITIS".

b.) Also observed on the POS was: "PICC line-Measure arm circumference 3 inches above PICC line catheter insertions site weekly with dressing change one time a day every Tue [Tuesday] related to CELLULITIS"

The electronic MAR (medication administration record) and the TAR (treatment administration record) were reviewed. The order to measure the arm circumference was not observed on the MAR or the TAR. The nurse's notes section was reviewed. There were no entries in the nurse's notes that the arm circumference had been measured.

A meeting was held with the facility staff on 08/31/2016 at approximately 4:45 p.m. The above information was discussed. The DON (director of nursing) stated that measurements had not been done since the time of Resident #202's admission. She stated that she thought the problem had been how the order had been entered into the system and that it was not showing up on the MAR or TAR. The DON was asked if there was a hospital measurement of the arm to be used as a baseline. She stated, "I don't know, I have only been here three weeks, he has been here longer than that, but I will find out."

On 09/01/2016 at approximately 8:40 a.m., the DON presented additional information to the survey team. She stated that the arm circumference had been measured and was 32

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cm (centimeters), she also stated that there had not been any measurements from the hospital to compare it to. The DON was asked if there was any documentation that the measurement had been obtained at any time since his admission. She stated, "No, it has not been done."

During a meeting with the administrator, OS #4, and the corporate nurse consultant at 9:45 a.m. this surveyor asked why the order that was on the physician order sheet was not on the MAR or TAR for the nurse to carry out. The administrative team did not have an answer.

The corporate nurse consultant brought a computer generated list of orders that had been signed off and/or discontinued for Resident #202. The order for measurements was not on the list. The corporate nurse consultant was asked if the orders viewed on the electronic POS were considered current and active orders. She stated "Yes." The corporate nurse consultant was asked if the orders on the electronic POS should be carried out as written. She stated, "Yes."

At approximately 11:25 a.m., the facility Instructor for the electronic record system came to the conference room. She stated, "Any order on the POS should be on the MAR or TAR...whether or not it shows up when printed is based on the parameters used when they printed it off for you." She then pulled up the electronic record. She stated, "I can tell the system to show me what the nurse would see on Tuesdays when the orders are pulled up." She pulled up an order screen as it would be seen by the nurse. The screen she pulled up had rectangles/cubes with orders written in each rectangle. She stated, "When the orders are done they change colors...when an

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(F 309)	Continued From page 12 order is red It means it was not carried out." She pointed to the screen. The order, "PICC line-Measure arm circumference 3 inches above PICC line catheter insertions site weekly with dressing change one time a day every Tue related to CELLULITIS" was red. She stated, "It was on here but the nurse never checked it off as completed." No further information was obtained prior to the exit conference on 09/01/2016.	(F 309)		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT Is not met as evidenced by: Based on observation, resident interview, staff interview and clinical record review, the facility staff failed, for one of 10 residents in the survey sample, to ensure safe storage of a portable oxygen tank. An unsecured portable oxygen tank was stored in Resident #208's room. The findings include: Resident #208 was admitted to the facility on 8/20/16 with diagnoses that included chronic obstructive pulmonary disease (COPD), heart disease, diabetes and high blood pressure. The	F 323	**F323** **09/08/16** **How the corrective action will be accomplished for the resident(s) affected.** Oxygen cylinder was immediately removed and properly secured for patient #208 on 8/31/2016. **How corrective action will be accomplished for those residents with the potential to be affected by the same practice.** No other unsecured oxygen cylinders were noted during rounds of current patients. **Measures in place to ensure practices will not occur.** Current staff will be in-serviced on maintaining a safe environment by ensuring oxygen cylinders are properly stored and secured.	

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F 323	Continued From page 13 admission nursing assessment dated 8/20/16 assessed Resident #208 as alert and oriented to person, place but not time or situation. On 8/31/16 at 1:38 p.m. Resident #208 was in her room sitting on the side of her bed. The resident had oxygen administered from an oxygen concentrator with use of a nasal cannula. An unsecured portable oxygen tank was standing upright in the floor across from the resident between the resident's walker and the wall. The oxygen tank was free standing and not in any type of stand, rack or cart. The gauge on the oxygen tank indicated the tank was slightly less than half full. Another portable oxygen tank was on the back of the resident's wheelchair secured in a storage sleeve. Resident #208 was interviewed at the time of this observation about the unsecured oxygen tank. Resident #208 stated she used a portable tank when she went out of her room in her wheelchair. Resident #208 stated she was not sure what the unsecured tank was in her room for because she had a tank attached to her wheelchair. Resident #208 stated she came to the facility with a portable tank from home. Resident #208 stated the unsecured tank must be "an extra" and it might have been the tank she brought from home but she was not sure. Resident #208 did not know how long the unsecured cylinder had been in her room. On 8/31/16 at 1:40 p.m. accompanied by the licensed practical nurse (LPN #2) caring for Resident #208, the unsecured oxygen cylinder was observed in the resident's room. LPN #2 was interviewed at this time about the unsecured cylinder and storage of oxygen tanks on the unit. LPN #2 stated the resident came from home with her own portable tank. LPN #2 stated the	F 323	**How the facility plans to monitor and ensure correction is achieved and sustained** Leadership staff will conduct daily rounds 5 times a week for 4 weeks to ensure oxygen cylinders are properly stored and secured. Any deficient practice will result in re-education or disciplinary action as indicated. Findings will be reviewed at the Q&A meeting for tracking and trending.	

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F 323	Continued From page 14 unsecured tank in Resident #208's room was not provided by the facility's oxygen vendor because it had a different connector on the top of the tank. LPN #2 removed the tank and stated oxygen tanks were supposed to be stored in racks and/or carts in the unit's central supply room. On 8/31/16 at 1:45 p.m. accompanied by LPN #2, the central supply room was inspected. In this room were multiple full and empty oxygen tanks securely stored and labeled in stationary metal racks and/or on small wheeled transportation racks. The facility's policy titled Respiratory/Oxygen Equipment (effective 8/4/15) documented concerning oxygen cylinder use, "Maintain proper storage, internal transportation and use of oxygen cylinders. Oxygen cylinders must be kept secure...Do not allow oxygen cylinder to be overturned or sustain a blow that may break off the top...Tanks must be in a cart or stand made for the type of tank being used or stored in a rack..." These findings were reviewed with the administrator and director of nursing during a meeting on 8/31/16 at 4:45 p.m.	F 323		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient	F 514	**F-514** **How the corrective action will be accomplished for the resident(s) affected.** Signed/faxed copy of Vancomycin order was placed in medical record and entered into Point Click Care. Order was obtained to discontinue circumference measurements above PICC line for Patient #202.	**09/08/16**

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F 514	Continued From page 15 information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure an accurate clinical record for one of 10 residents in the survey sample. Resident #208's medication administration record documented no administration of two medications for ten days in August 2016. The findings include: Resident #208 was admitted to the facility on 8/20/16 with diagnoses that included chronic obstructive pulmonary disease (COPD), heart disease, diabetes and high blood pressure. The admission nursing assessment dated 8/20/16 assessed Resident #208 as alert and oriented to person and place but not time or situation. Resident #208's clinical record documented physician orders dated 8/20/16 for the medication Protonix 40 mg (milligrams) to be administered daily for Indigestion and Spiriva 18 mcg (micrograms) to be administered daily for the treatment of COPD. The physician orders indicated these medications were self-administered by the resident. The resident's medication administration record (MAR) for August 2016 documented these medications were not administered for ten consecutive days from 8/21/16 through 8/30/16. The spaces on the	F 514	**How corrective action will be accomplished for those residents with the to be affected by the same practice.** Current patients were reviewed and no other patients were identified with incorrect PICC antibiotic orders. No other patients had PICC circumference measurements ordered. **Measures in place to ensure practices will not occur.** Charge nurses will be in-serviced on the process for obtaining pharmacy faxed orders to ensure timely, accurate order entry and notification to the physician. Nurses will be in-serviced on correct order entry for PICC lines. **How the facility plans to monitor and ensure correction is achieved and sustained.** DON/designee will review pharmacy faxed orders for accurate order entry and physician notification 5 times a week for 4 weeks to ensure an accurate clinical record. Any deficient practice will result in re-education or disciplinary action as indicated. Findings will be reviewed at the Q&A meeting for tracking and trending.	

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F 514	Continued From page 16	F 514		

MAR for the nurses' sign off indicating administration of the medications were blank. The clinical record documented no notes regarding the Protonix or the Spiriva.

On 8/31/16 at 2:55 p.m. the licensed practical nurse (LPN #1) caring for Resident #208 was interviewed about the missing documentation concerning the Protonix and Spiriva. LPN #1 stated Resident #208 did not self-administer any medications. LPN #1 stated she had entered the orders for the Protonix and Spiriva into their computer system and marked them as self-administered medications when they should have been listed as administered by the nurses. LPN #1 stated when medications were marked as self-administered the administration was not reflected on the MAR report. LPN #1 stated the medications were administered to the resident as ordered. LPN #1 stated their medication administration system highlighted medicines in red if they were late or not given. LPN #1 stated the medications should not have been categorized as self-administered when the orders were originally entered.

On 8/31/16 at 3:30 p.m. the director of nursing (DON) was interviewed about the blanks on Resident #208's MAR from 8/21/16 through 8/30/16. The DON stated she had reviewed the medication administration system and interviewed the nurses caring for Resident #208 and stated the medications were given as ordered. The DON stated, "They [nurses] gave the meds [medications]." The DON stated the orders were marked as self-administered medicines in error and the nurses did not realize this resulted in blanks on the MAR report.

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F 514	Continued From page 17 These findings were reviewed with the administrator and director of nursing during a meeting on 8/31/16 at 4:45 p.m.	F 514		